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	175531	A. BUILDING _____ B. WING _____	R 02/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATCHISON SENIOR VILLAGE	1419 N 6TH ST ATCHISON, KS 66002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-Compliance Revisit. A revised copy of the deficiencies was sent to the facility on 3/3/14.	{F 000}		
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility had a census of 49 residents. Based upon observation, record review, and interview the facility failed to provide services in a timely manner for 1 (#17) of 3 residents sampled for activities of daily living. Findings included: - Resident #17's significant change Minimum Data Set (MDS) 3.0 dated 12/30/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, and had no behaviors. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, toilet use, did not walk in the room/corridor, was totally dependent upon staff for locomotion on/off the unit and personal hygiene, and required limited staff assistance with eating.	{F 312}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The resident's care plan review 1/13/14 included the resident required assistance of 2 staff to get out of bed and dress in the morning. Staff toileted the resident after getting him/her up and assisted the resident with his/her dentures. The resident required assistance of 2 staff for bed mobility, transfers, and toileting. The resident could make slight changes in his/her position but not enough to relieve pressure so staff turned/repositioned the resident every 1 to 2 hours and at times the resident was totally dependent upon staff with eating.

A hospice note dated 2/14/2014 and timed 10:02 A.M. included the resident ate his/her breakfast in bed upon arrival. The resident reported difficulty in feeding himself/herself. Hospice staff assisted the resident to eat the cream of wheat and the resident drank most of his/her nutritional supplement. The note documented hospice staff reported the above to facility staff.

On 2/20/14 at 10:37 A.M. observation revealed the resident was in bed, the head of the resident's bed was up approximately 30 degrees and the resident attempted to feed himself/herself breakfast. The resident was not positioned high enough in the bed. Observation also revealed the resident had difficulty getting the cream of wheat to his/her mouth. The resident stated he/she was having difficulty eating, needed to be positioned higher in the bed and the cereal was cold so did not taste good. The resident did not know the exact time staff delivered his/her breakfast meal but stated it was a while ago. At that time (10:37 A.M.) the surveyor activated the resident's call light and staff responded to the resident's call light at 10:42 A.M.

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On 2/24/14 at approximately 8:40 A.M. observation revealed the resident in bed, and the resident's breakfast in front of him/her and the resident attempted to get his/her top denture in. The resident stated he/she could not get his/her denture in and asked for assistance. The resident stated some mornings staff assisted him/her with placing his/her dentures and other mornings they did not.

On 2/24/14 at 10:45 A.M. the resident sat in his/her recliner. At approximately 12:15 P.M. direct care staff I was in the resident's room. Direct care staff I stated staff transferred the resident to the recliner at approximately 10:30 A.M. and at 11:50 A.M. staff offered to toilet the resident, the resident did not need to use the bathroom and staff repositioned the resident by placing a pillow under his/her right side.

On 2/24/14 at 2:30 P.M. direct care staff I and direct care staff J were in the resident's room preparing to transfer the resident from the recliner to the toilet. During interview with direct care staff I at that time, he/she stated at 11:50 A.M. staff repositioned the resident by placing a pillow under his/her right side and the resident had sat in the recliner without positioning since then (duration of 2 hours and 40 minutes).

On 2/25/14 at 8:15 A.M. and at 8:35 A.M. the resident sat in his/her wheelchair in the dining room. At 8:35 A.M. the resident said to the surveyor you are the "fourth person I have asked to take me to the bathroom and no one will take me". The resident stated he/she received a laxative the night of 2/24/14 and he/she needed to go to the bathroom. Licensed nurse D present

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at the time, asked nursing administrative staff E if he/she would assist the resident to the bathroom. Licensed nurse E stated staff was toileting another resident and staff would toilet the resident after they were done with the other resident. At 8:45 A.M. direct care staff K and L transferred the resident to the toilet. As staff prepared to transfer the resident, the resident stated "hurry, I really have to go". The resident had a bowel movement immediately after staff sat him/her on the toilet.

On 2/25/14 nursing administrative staff E stated staff toileted the resident at 7:40 A.M.

On 2/25/14 at approximately 4:40 P.M. licensed nurse F stated staff offered to toilet the resident every 2 hours, staff should assist the resident with placement of his/her dentures and some days the resident was dependent upon staff with eating.

On 2/25/14 at approximately 5:00 P.M. direct care staff M stated the resident required assistance of 2 staff for transfers and bed mobility, staff offered to toilet the resident every 2 hours and on some days the resident was dependent upon staff for eating.

The facility's undated Dependent Resident Protocol included the facility assessed residents for functional status and assistance required of staff was determined.

The facility failed to reposition this resident at least every 1 to 2 hours as care planned, failed to assist the resident with his/her meals, placement of his/her dentures, and failed to assist the resident to the bathroom in a timely manner.

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{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	{F 314}		

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 49 residents. Sample size included 3 residents for pressure ulcers. Based upon observation, record review and interview the facility failed to provide services to promote healing of pressure ulcers for 2 (#47, #59) residents of the sample.

Findings included:

- Resident #59's admission Minimum Data Set (MDS) 3.0 dated 1/21/14 identified the resident was admitted to the facility on 1/10/14, scored 14 (cognition intact) on the Brief Interview for Mental Status, did not have behaviors, required extensive staff assistance with bed mobility, transfers, dressing, and toilet use, did not walk in room/corridor, was dependent upon staff with locomotion on/off the unit, required staff assistance with set-up during eating and staff supervision with personal hygiene. The MDS identified the resident was frequently incontinent of urine and was at risk for the development of pressure ulcers. The MDS identified the resident had an unstageable pressure ulcer due to slough

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(non-viable tissue)/eschar (dead tissue) not present upon admission. The MDS recorded the unstageable pressure ulcer measured 1.3 centimeters (cm) by 0.7 cm with a depth of 0.1 cm. The MDS recorded the resident had a pressure relieving device for his/her chair and bed and was not on a turning/repositioning program.

The resident's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 1/22/14 included the resident had a self-care deficit, needed more help with his/her ADL's due to acute pain in his/her back and left leg and foot. The resident was unable to walk, needed 2 staff for transfers and the resident could not perform his/her ADL's without staff assistance.

The resident's Urinary Incontinence CAA dated 1/22/14 documented the resident was incontinent of urine. Staff offered to toilet the resident every 2 hours and as requested per the resident.

The resident's undated admission care plan included staff repositioned the resident every one to 2 hours, the resident moved slowly, did not ambulate, and required staff assistance with mobility.

A care plan dated 1/28/14 included the resident had 3 ulcers with slough on his/her buttock, the ulcer on the resident's coccyx was healing, staff repositioned the resident every 1 to 2 hours and placed a wedge to keep the resident from rolling onto his/her back. The resident received Breeze (a nutritional supplement), cottage cheese, and Prostat (a protein supplement) which increased the resident's protein. The resident requested more cottage cheese.

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The resident's care plan reviewed 1/22/14 included staff repositioned the resident every 1 to 2 hours and floated the resident's heels. Staff monitored the resident's nutritional status, and monitored and documented the resident's meal consumption. On 1/17/14 the resident started on Prostat (protein supplement) and vitamins per the facility wound protocol. An entry dated 1/21/14 included the resident tended to roll back on his/her back and staff used a wedge cushion to see if the wedge cushion held the resident's position better. Staff also used pillows for support as needed. The resident required assistance of 1 to 2 staff when getting in/out of bed. The resident required staff assistance when incontinent of urine and staff offered to toilet the resident at least every 2 hours. The resident liked staff to offer him/her house shakes at snack times. An entry dated 1/21/14 included on 1/16/14 staff observed the resident had (3) areas of skin breakdown on his/her buttock. On 1/22/14 the Registered Dietician (RD) visited with the resident and the resident now received Breeze (nutritional supplement) and cottage cheese at lunch and upper. An entry dated 2/6/14 included the resident did not like the Prostat but agreed to eat more cottage cheese.

A laboratory report dated 11/1/13 recorded the resident's total serum protein level as 5.5 grams/deciliter (g/dL) normal reference range at 6.4-8.2 g/dL and the resident's serum albumin (type of protein) level at 2.7 g/dL normal reference level 3.4-5.0 g/dL.

A physician's order dated 1/17/14 and timed 3:36 P.M. included for the resident to receive 30 cubic centimeters (cc's) of Prostat daily with juice.

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Review of the resident's weight log revealed the following weights:
1/19/14: 134 pounds
1/23/14: 131 pounds
1/30/14: 131 pounds
2/06/14: 129.4 pounds
2/13/14: 124 pounds (a decrease of 10 pounds and/or 7.46 percent weight loss in 1 month).

A RD note dated 1/21/14 included the resident needed 88 grams of protein per day. The resident had (3) unstageable pressure ulcers on his/her buttock/coccyx and the resident received a regular diet with 30 cc's of Prostat on a daily basis.

A RD note dated 1/30/14 documented the resident's food consumption at meals decreased; the resident had an upset stomach. The resident's weight was down 5 pounds in the past 2 weeks. The RD recommendations included staff to serve the Prostat in the resident's orange juice prior to serving the meal.

A dietary request dated 1/22/14 included for the resident to receive 30 cc's of Prostat in his/her orange juice at the breakfast meal, peach or orange Breeze at the lunch and supper meal, and a small bowl of cottage cheese at lunch and supper.

A dietary request dated 2/19/14 documented for the facility to please try another supplement drink as the resident hated the present one and the resident's biggest issue now was nausea and weight loss.

A RD note dated 2/22/14 included the resident

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continued to have an upset stomach due to increase acid in foods and the facility would offer the resident bread with jelly at lunch and supper per resident's request and provide lemon lime soda 4 ounce with meals.

A skin/wound note dated 1/16/14 and timed 4:40 P.M. included staff observed the resident had a small open area to his/her right buttock that measured 0.4 cm by 0.5 cm. The resident had 4 other areas that were Stage 1 pressure ulcers with redness and were not blanchable. The one area above the open area on the right buttock measured 1 cm by 1.2 cm and the area on the resident's coccyx measured 1.2 cm by 1.0 cm and two areas on the resident's left buttock, the one most proximal to the resident's waist measured 0.5 cm by 0.7 cm and the one lower measured 0.3 cm by 0.3 cm. Staff floated the resident's heels with pillows and repositioned the resident every 1 to 2 hour. Staff educated the resident on the need to turn from side to side for a while until the areas healed. The resident stated okay and direct care staff was educated on the need to turn the resident from side to side to keep the resident off his/her back.

A nurse's note dated 1/21/2014 and timed 3:20 P.M. documented the resident had (3) unstageable wounds at this time. The (1) Stage 2 pressure ulcer had 100 percent (%) yellow slough (non-viable tissue) in the wound bed and the pressure ulcer measured 0.4 cm x 0.5 cm and had a depth of 0.1 cm in depth. The second wound was to the left and slightly above the one described above and measured 1 cm by 0.3 cm with a depth of 0.1 cm with 100% yellow slough to the wound bed The third wound on the resident's coccyx measured 1.3 cm by 0.7 cm

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with a depth of 0.1 cm and had 100% yellow slough in the wound bed. The resident continued on the facility's wound care protocol and received a Multivitamin and Prostat and the resident's appetite varied depending on the meal. Staff repositioned the resident every 1 to 2 hours. The resident had back pain and did not like to lie on his/her side. When staff assisted the resident to his/her side, the resident did not stay there and managed to reposition on his/her back again. Staff educated the resident on the need to stay off his/her back and what could happen to the areas if he/she did not. The resident was incontinent at times. The facility placed a turn clock in the resident's room and the facility ordered a wedge to keep the resident on his/her side.

A nurse's note dated 1/30/2014 and timed 5:37 P.M. documented staff notified the resident's physician the 2 areas to the resident's right buttock were healed and the ulcer to the resident's coccyx remained.

A wound care clinic consultation note dated and signed by a physician on 2/11/14 documented the resident had an unstageable pressure ulcer on his/her lower back. The area had extensive slough and measured 0.9 cm with a depth of 0.1 cm.

A wound care clinic consultation note dated and signed by a physician on 2/18/14 documented the resident had an unstageable pressure ulcer on his/her lower back. The area had extensive slough, the status of the wound deteriorated and measured 1.8 cm by 0.7 cm with a depth of 0.4 cm and staff to keep weight off the resident's sacrum at all times.

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A wound care clinic note dated and signed by a physician on 2/25/14 documented prior to debridement the unstageable pressure ulcer on the resident's sacrum measured 1.3 cm by 0.8 cm depth of 0.5 cm with extensive slough. After debridement the majority of wound base was viable, appeared to be granulation tissue and was likely a stage III pressure ulcer.

Review of the facility's snack roster included the resident received a house shake at 10:00 A.M. and 2:00 P.M. Review of the snack roster from 2/1/14 to 2/24/14 revealed the facility did not consistently document the percentage of the house shake the resident drank.

Review of the facility's dietary logs from 2/1/14 to 2/24/14 revealed the facility did not consistently document the percentage of the orange juice that contained the Prostat, the Breeze, or the cottage cheese the resident consumed.

On 2/20/14 at 10:30 A.M. the resident's breakfast meal remained on his/her bedside table. Observation revealed the resident consumed 75% of the sausage patty, half the scrambled eggs, half the toast, none of the cream of wheat or the orange juice.

On 2/20/14 at 12:10 P.M. staff delivered the resident's lunch tray which consisted of turkey a la king, a biscuit, a vegetable, a bowl of cottage cheese, a cup of milk and a cup of Breeze. At approximately 12:30 P.M. the resident had finished eating the meal and observation revealed the resident consumed ½ of the turkey a la king, none of the vegetables, all the cottage cheese, all the milk and none of the Breeze. During

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interview with the resident at that time he/she stated his/her stomach was upset the last week or so, was getting better, and his/her appetite had improved. The resident stated he/she received cottage cheese at lunch and dinner, although he/she liked cottage cheese but was tired of eating it twice a day every day. The resident stated he/she had a pressure ulcer on his/her bottom which was why he/she received the cottage cheese and the Breeze. The resident stated he/she did not like the taste of the Breeze.

On 2/20/14 at approximately 12:35 P.M. direct care staff S and T entered the resident's room. Direct staff S and T transferred the resident from the wheelchair to the bed. Observation revealed they positioned the resident in bed on his/her right side using a body pillow and 2 standard size pillows.

On 2/24/14 at approximately 12:30 P.M. the resident ate the lunch meal which consisted of turkey and dressing, green beans, macaroni and cheese, beans and rice, and cabbage. Observation did not reveal cottage cheese or bread with jelly on the resident's lunch tray. Observation revealed the resident had a cup of milk and a cup of Breeze. The resident consumed all the milk and did not consume any of the Breeze. The resident stated he/she liked milk but did not like the taste of the Breeze.

On 2/24/14 at approximately 12:45 P.M. licensed nurse X performed the treatment to the resident's pressure ulcer. Observation revealed the resident had an unstageable pressure ulcer on his/her sacrum and the center of the pressure ulcer had an area with white colored tissue.

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On 2/25/14 at approximately 8:30 A.M. the resident sat in his/her wheelchair and ate his/her breakfast which included cream of wheat, scrambled eggs, toast, sausage patty, bowl of cottage cheese, a cup of milk, and a cup of orange juice with a brownish color. Observation revealed the resident did not receive applesauce. The resident stated the orange juice contained vitamins and he/she did not like the taste of the orange juice; therefore he/she did not drink it. The resident stated staff was aware he/she did not drink the orange juice or the Breeze because he/she did not like the taste.

On 2/25/14 at 10:15 A.M. and 11:00 A.M. observation revealed the snack cart sat by the day room located on the 100 hall. Review of the snack roster lacked evidence to support the resident received the 10:00 A.M. snack. At approximately 11:30 A.M. review of the snack roster did not support the resident received his/her 10:00 A.M. snack. During interview with direct care staff N stated staff did not pass the 10:00 A.M. snacks.

On 2/25/14 at 12:44 P.M. administrative nursing staff B stated he/she received a physician's order to discontinue the Prostat because the resident refused to take it. Administrative nursing staff B stated the resident would receive double eggs at breakfast and peanut butter and jelly sandwiches at snack times. Administrative nursing staff B stated the RD note dated 2/22/14 read the resident received bread with jelly at lunch and supper only when the resident requested it. Administrative nursing staff stated the resident received Breeze twice a day. Administrative nursing staff B did not acknowledge whether the resident consumed the Breeze.

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On 2/25/14 at 3:05 P.M. administrative nursing staff C stated the facility attempted the wedge cushion but it did not work. Administrative nursing staff B entered the room and stated the wedge was the wrong size, it was too narrow at the end, therefore it did not work and the facility did not have the proper size wedge in stock.

On 2/25/14 at approximately 4:00 P.M. dietary consultant P stated he/she visited with the resident on 2/22/14. The resident agreed to take the Prostat if staff placed it in applesauce. Dietary consultant P stated the resident liked bread with jelly and requested it at lunch and dinner. Dietary consultant P stated he/she was not aware the resident did not drink the Breeze. Dietary consultant P stated it was his/her expectation staff monitored and documented the percentage of all nutritional supplements the resident received. Dietary consultant P stated Prostat provided protein whereas Breeze provided calories and some protein. Dietary consultant staff P stated residents had to receive enough calories to set protein aside in order to promote wound healing. Dietary consultant P stated if residents did not receive enough calories then the proteins would not be set aside which interfered with wound healing.

On 2/25/14 at approximately 4:20 P.M. administrative staff A confirmed the dietary department did not receive the RD's recommendation regarding placing the Prostat in applesauce and to provide the resident with bread with jelly at lunch and supper.

On 2/25/14 at approximately 4:35 P.M. licensed nurse F stated staff repositioned the resident at

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least every 2 hours. Licensed nurse F stated when in bed, staff used pillows to keep the resident off his/her back, at times the resident removed the pillow and laid on his/her back.

On 2/25/14 at approximately 5:03 P.M. direct care staff M stated staff repositioned the resident at least every 2 hours. Direct care staff M stated he/she did not see a wedge in the resident's room and when in bed, staff placed pillows to position the resident on his/her sides.

The facility's undated Pressure Ulcer Protocol included nutritional interventions after the development of pressure ulcers.

The facility failed to implement alternative nutritional supplements in a timely manner, failed to consistently document the percentage of the nutritional supplements, and failed to follow the dietician's recommendations to promote the improvement of the pressure ulcer this resident had.

- Resident #47's significant change Minimum Data Set (MDS) 3.0 dated 1/8/14 identified the resident scored 2 (severely impaired cognition) on the Brief Interview for Mental Status, did not have behaviors, required extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, eating, toilet use and personal hygiene, and did not walk in the room/corridor. The MDS identified the resident was at risk for the development of pressure ulcers, did not have pressure ulcers, had a pressure relieving device on his/her bed, no pressure relieving device in his/her chair and was on a turning/repositioning program.

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The resident's significant change MDS dated 1/23/14 identified the resident had short and long term memory problems and moderately impaired cognition. The MDS coded the resident did not have behaviors, required extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, eating, toilet use, and personal hygiene and did not walk in the room/corridor. The MDS coded the resident had (2) stage 2 pressure ulcers not present upon admission and the date of oldest stage 2 pressure ulcer was 1/14/12. The MDS recorded the resident had a pressure relieving device for his/her bed and chair and was on a turning/repositioning program.

The resident's Pressure Ulcer Care Area Assessment (CAA) dated 1/9/14 documented the resident had a diagnosis of diabetes mellitus (when the body cannot use glucose, there's not enough insulin made or the body can ' t respond to the insulin) and had the potential for alteration in skin integrity. The resident had a healed stage 1 pressure ulcer on his/her buttock in the recent past and staff continued to apply a moisture barrier to the area. The resident utilized a wheelchair for locomotion and staff repositioned the resident every 1 to 2 hours.

The resident's Nutritional Status CAA dated 1/24/14 documented the resident had (2) Stage 2 pressure ulcers (one on each heel) and staff offered the resident's snacks.

The resident's Pressure Ulcer CAA dated 1/25/14 included the resident had (2) Stage 2 pressure ulcers (1 on each heel); required staff assistance with repositioning and staff floated the resident's heels when he/she sat in the wheelchair.

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The resident's care plan dated 1/5/14 included staff encouraged and assisted the resident at meals. The resident liked root beer pop and ice cream. The resident required supplemental protein, amino acids (play central roles as building blocks of proteins), vitamins, minerals to promote wound healing, and received 30 cubic centimeters (cc's) of Prostat (protein supplement) once a day and a Registered Dietician (RD) assessed the resident's nutritional status as needed. On 1/14/14 staff observed the resident had blisters on both of his/her heels and the resident required more staff assistance with mobility. Staff floated the resident's heels in bed and when he/she sat in the wheelchair. Staff repositioned the resident every 1 to 2 hours.

Review of the resident's care plan dated 1/11/14 included the following in place since 6/18/13: the resident had a potential for alteration in his/her skin integrity, staff applied lotion to the resident's skin each day and a licensed nurse assessed the resident's skin on a weekly basis. The resident's care plan did not include repositioning or floating the resident's heels.

A laboratory report dated 12/23/13 recorded the resident's albumin (type of protein) level at 3.1 grams/deciliter (normal reference range 3.4 to 5 grams/deciliter).

A RD note dated 1/8/14 included the resident required 67 grams of protein/day.

A RD note dated 1/15/14 included the resident had blisters on both of his/her heels and staff initiated the facility's wound care protocol. The facility started the resident on Prostat 30 cc's

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each day.

A RD note dated 1/31/14 included the resident continued to receive the Prostat. Hospice supplied Boost and Breeze (nutritional supplements used to increase calories) and staff provided the nutritional supplements to the resident three times a day with meals.

A weight change note dated 1/30/2014 and timed 4:43 P.M. documented the resident weighed 115 pounds, the resident liked root beer and ice cream; staff would provide the resident with a root beer float at 10:00 A.M. and 2:00 P.M. to see if this would help with the resident's weight and dietary received an order to include root beer on the snack cart. The note included the resident did not always eat well at meals.

A nutrition/dietary note dated 2/21/2014 and timed 5:24 P.M. documented the resident's weight varied slightly over the month. On 1/21/14 the resident weighed 117 pounds and on 2/21/14 the resident weighed 116 pounds. Staff provided the resident the Breeze or Boost three times a day with meals and was well received by the resident. The facility would add house shake at snack time to promote the resident's weight gain.

A dietary request dated 2/21/14 included for the resident to receive house shakes between meals at snack times.

Review of the facility's snack roster on 2/25/14 at approximately 10:00 A.M. revealed the resident's name was included to receive a root beer float at the 10:00 A.M. snack pass. The roster did not include the resident received a house supplement or float at the 2:00 P.M. or night snack pass.

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Review of the resident's dietary log since 1/15/14 to 2/24/14 lacked evidence to support the resident received Boost or Breeze at meals.

A skin/wound note dated 1/14/14 and timed 6:22 P.M. documented on the morning of 1/14/14 staff observed the resident had fluid filled blisters on both of his/her heels. The blister on the resident's left heel measured 3 centimeters (cm) by 6 cm and the blister on the resident's right heel measured 2.75 cm by 2.5 cm. The facility instructed the direct care staff to float the resident's heels at all times, no shoes, and only gripper socks.

A skin/wound note dated 1/21/2014 timed 4:18 P.M. documented the resident continued with the (2) Stage 2 pressure ulcers on his/her bilateral heels. The right heel had an intact fluid filled blister that measured 2.75 cm by 2.5 cm. The blister on the resident's left heel had reabsorbed the skin was intact and, discolored and measured 3 cm x 6 cm.

A skin/wound note dated 1/28/2014 and timed 4:52 P.M. included the resident continued to have the stage 2 ulcer on his/her heels. Staff observed a pea sized area of fluid left in the blister on the resident's left heel, the area surrounding the fluid filled area was brown in color and the area measured 2.7 cm x 4.4 cm. The pressure ulcer on the resident's right heel was unstageable and measured 2.4 cm x 2.5 cm.

A general note dated 2/18/2014 and timed 2:54 P.M. included the blister on the resident's right heel measured 2.5 cm at the 12 and 6 clock position and 4.0 cm at 3 to 9 clock. The skin over

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the blister was dark purple.

The blister on the resident's left heel measured 2.8 cm at 12 to 6 clock position and 4.7 cm at 3 to 9 clock position.

On 2/20/14 at 12:25 P.M. the resident sat in his/her wheelchair at a dining room table and ate the lunch meal which consisted of turkey a la king, biscuit, vegetables, applesauce, apple crisp, yogurt, water and coffee. Observation revealed the resident ate independently. At 12:35 P.M. the resident ate ice cream. At 12:45 P.M. the resident was finished eating and observation revealed the resident consumed all the applesauce, apple crisp, yogurt, ice cream and fluids. The resident did not eat the vegetables or turkey a la king. The staff did not provide the boost or breeze.

On 2/24/14 at 8:15 A.M. the resident sat in his/her wheelchair at a dining room table and ate the breakfast meal. Observation revealed the meal included cream of wheat, eggs, juice and milk. The staff did not provide the boost or breeze. At 8:30 A.M. the resident had consumed all the fluids.

On 2/24/14 at approximately 2:30 P.M. licensed nurse F performed the treatment on the resident's heels. Observation revealed the center of the resident's right heel had a pin point area and the resident's left heel had a raised dark colored spot.

On 2/25/14 at 10:15 A.M. and 11:00 A.M. observation revealed the snack cart sat by the day room located on the 100 hall. Review of the snack roster lacked evidence to support the resident had received his/her 10:00 A.M. snack.

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At approximately 11:30 A.M. review of the snack roster did not support the resident received his/her 10:00 A.M. root beer float. Direct care staff N stated staff did not pass out the 10:00 A.M. snacks.

On 2/25/14 at approximately 11:45 A.M. nursing administrative staff B stated some of the snacks were passed and others were not and confirmed the snack roster lacked evidence to support the resident received his/her 10:00 A.M. snack.

On 2/25/14 at approximately 4:00 P.M. dietary consultant P stated he/she recently assessed the resident's nutritional status. Dietary consultant staff P stated it was his/her expectation staff monitored and documented the percentage of all nutritional supplements the resident received. Dietary staff P stated Prostat; a protein supplement increased protein, whereas Boost and Breeze provided calories and some protein. Dietary staff P stated it was his/her understanding the resident received either Boost or Breeze at meals and health shakes between meals. Dietary consultant staff P stated residents had to receive enough calories to set protein aside in order to promote wound healing. Dietary consultant P stated if residents did not receive enough calories the proteins would not be set aside which interfered with wound healing.

On 2/25/14 at approximately 4:20 P.M. administrative staff A confirmed the facility's snack roster did not support the resident received the health shakes three times a day since 1/31/13. Administrative staff A confirmed the facility did not monitor the percentage of the Breeze or Boost the resident consumed at meals and confirmed there was no evidence to support

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the resident received the Breeze or Boost at meal.

On 2/25/14 at approximately 4:30 P.M. licensed nurse F stated the resident received boots for Christmas and staff thought the boots contributed to the development of the blisters on the resident's heels. Licensed nurse F stated the resident was dependent upon staff for bed mobility and transfers.

On 2/25/14 at approximately 5:00 P.M. direct care staff M stated since the development of the blisters on the resident's feet, staff floated the resident's heels and the resident wore heel protectors when in bed. Direct care staff M stated the resident was dependent upon staff for bed mobility and transfers.

The facility's undated Pressure Ulcer Protocol included nutritional interventions after the development of pressure ulcers but did not included prevention of the development of pressure ulcers.

The facility failed to offer the resident the nutritional supplements as planned to promote pressure ulcer healing.